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D 000	Initial Comments The Adult Care Licensure Section and the Wake County Human Services conducted an annual survey and complaint investigation on December 16-19, 2014.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record review and interviews, the facility failed to assure that only staff meeting the requirements shall administer medications for 1 of 7 sampled residents who had a perineal rash (Resident #1).{Refer to 10A NCAC 13F .0403} The findings are: Review of the facility's incident report, dated 10/8/14, revealed: -At 6:45 am, 1st shift personal care manager (PCM) mistakenly fed Resident #1's anti-fungal, topical cream to the resident by mouth. -Poison Control was contacted; the staff was told by the agent that the resident was going to be fine. -The resident was monitored and had no apparent injury.	D 358		

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D 358	Continued From page 1 Review of Resident #1's current FL-2 dated 11/24/14 included diagnoses of hypertension (HTN), Dementia, Osteoporosis, chronic rectal prolapse with incontinence, peri-anal proctectomy with colon, anastomosis, macular erythema, dysphagia and gastro-esophagus disease (GERD), incontinent of bladder and bowel. Review of Resident #1's record revealed: -The resident was admitted to the facility's Special Care Unit (SCU) on 5/13/10. -On 10/8/14, the resident was spoon fed a teaspoon of Ketoconazole 2% cream/ Triamcinolone 0.1% cream by a personal care manager (PCM). -The medication administration records (MARs) revealed that Ketoconazole 2% cream/ Triamcinolone 0.1% cream, was scheduled to be administered at 8 am and 8 pm. -Medication order for Ketoconazole 2% cream/ Triamcinolone 0.1% cream, topical twice daily. (Ketoconazole cream is used to treat certain fungal infection of the skin; Triamcinolone cream is used to treat a variety of skin conditions such as eczema, dermatitis, allergies, rash) Review of Resident #1's "Individualized Service Plan (ISP)", dated 4/25/14, contained documentation under the category of "Skin Integrity", that staff will continue to monitor buttocks and apply ointment as ordered. Review of Resident #1's electronic Progress Notes, dated 10/2/14 at 3:34 pm, written by a Health and Wellness RN, revealed that "Staff reminded to put/apply barrier cream with every change." Interview with the facility's Health and Wellness RN, on 12/19/14 at 11:05 am, revealed:	D 358		

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-Care managers (CMs) have working "Individualized Service Plan (ISP) "on each floor to review for providing care to their assigned residents.
-Medication aides (MAs) use the MARs for their duties.
-Resident #1's electronic Progress Notes, dated 10/2/14, documented "staff " referred to a personal care manager.

Interview with the 1st shift PCM, on 12/16/14 at 2:05 pm & 12/17/14 at 9:40 am, revealed:
-On 10/8/14, the PCM was assigned to provide routine care to Resident #1 and this was the first time a medication aide (MA) gave him a white cream in a medication cup with a teaspoon to give it to Resident #1.
-When the MA gave the PCM the cream, the MA just told the PCM "this is for [Resident #1]".
-The PCM was not given any instruction from a MA when the cream was given.
-The PCM assumed the cream was for the mouth since the cream was thin, poured in a medication cup, and accompanied by a spoon.
-The PCM gave Resident #1 a teaspoon full of the cream.
-The PCM didn't know that the cream was for the resident's perineum area and the staff didn't realize an error was made until the1st shift LCM #1 told him.
-The PCM reported to the LCM #1 that Resident #1's buttocks area looked redder and appeared worse.
-During the PCM's job shadowing period, the PCM didn't observe Resident #1's care so was not aware that the resident was to receive a prescription cream for rash on the resident's perineum area.
-The PCM used non-prescription cream on Resident #1's buttocks area, applying the cream

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2-3 times during the shift, when changing the resident in the past.
-During PCM's training, someone had shown him where all the toiletries were kept in the resident's room and over the counter (OTC) cream was also kept there.
-No one had told the PCM specifically when to use the OTC cream but it was there so he used it.
-The PCM and SIC contacted the Poison Control and was told that the resident was not in an immediate danger to life but might experience intestinal distress.
-The PCM monitored the resident throughout his shift and didn't observe any medical issues.
-The PCM reported to the administrator and the special care unit coordinator (SCUC) about the incident and had written a statement.

Review of personnel records of the1st shift PCM and 1st shift MA, on 12/18/14, revealed:
-PCM was hired on 9/3/14 as a care manager and is a nurse aide.
-There was no documentation the PCM had completed a medication administration clinical skills validation checklist.

Review of the facility's job description for "Care Manager" did not reveal administration of medications, including topical creams, as one of the duties.

Observation of Resident #1's toiletry box, in a locked cabinet in the room, on 12/15/14 at 5:30 pm revealed a tube of "White Petrolatum Skin Protectant".

Interview with the 1st shift MA, on 12/16/14 at 11:30 am and 12/18/14 at 5:20 pm, revealed:
-The MA has been working at the facility for 16 years and it was the first time this kind of

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medication error happened under her watch.
-The MA was assigned to pass medications in the 2 SCUs located on the 3rd floor and the basement.
-The MA gave the topical rash cream for Resident #1 to the PCM and told the PCM to apply to the perineum area.
-It was the first time the MA gave the cream to the PCM.
-The SIC informed the MA that the PCM fed the cream to Resident #1; the resident's primary care physician (PCP) and family member were notified of the incident.
-The PCM told the MA that he thought it was for feeding.
-In the past, the cream was applied by the care managers and they notified the MA after the task was done and the MA documented on the MAR.
-The facility management was not aware of MAs giving the cream to the care managers to apply.
-The practice of the PCM administering the topical cream started when the MA was ready to apply topical creams to the resident but the resident's cleaning care wasn't done by the PCM yet so instead of waiting for PCM to finish the task, the cream was given to the PCM to apply.
-Only one MA was assigned to administer medications to approximately 40 SCU residents on 2 floors (basement & 3rd floor), within required hours, therefore MA didn't have time to waste.
-After 10/8/14 medication error incident, all MAs signed the statement provided by the facility stating that all medications were to be administered by MAs only.

Interview with a 1st shift Lead Care Manager (LCM) #1 on 12/18/14 at 1:35pm revealed:
-Only the medication aide (MA) was responsible for applying prescription creams.
-It happened that the PCMs would apply the

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prescription creams.
-A PCM told the LCM that the PCM was given Rresident #1's cream by the MA and had given the cream orally.
-PCMs should not give out medications.
-The staff that gave out the cream made a statement of the incident and it was sent to the Executive Director.
-In the PCM job description it says PCMs do not give out medications.

Interview with a 1st shift Lead Care Manager (LCM) #2, on 12/18/14 at 1:15 pm, revealed:
-Resident #1 had one cream applied by the MA in the mornings.
-The resident's skin was red in her perineum area and the resident was incontinent of urine.
-All the PCMs used to apply the cream to the resident's perineum area but 2 months ago, PCMs were told by the special care unit coordinator that PCMs were not to apply any cream to residents, only MAs.
-There was an accident one morning; a new staff was given the cream in a small cup with a spoon and he thought the cream was supposed to be administered orally.
-The LCM did not know if the MA gave the PCM instructions.
-PCMs were not supposed to give out medications, but for past 2 years, PCMs had been administering the cream.
-When the PCM first started working, Resident #1 only had Vaseline to put on her bottom.
-When Resident was prescribed a prescription cream, the PCMs were given the prescription cream to use on her bottom.

Interview with a 2nd shift PCM, on 12/18/14 at 4 pm, revealed:
-The PCM had always gotten the topical cream

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from the MA and applied the cream before laying Resident #1 down for bed.
-The PCM never questioned, just followed the MA's instructions.
-After the 10/8/14 incident, the MA was the only staff who could apply the cream to Resident #1's rash.

Interview with the 2nd shift lead care manager (LCM), on 12/18/14 at 3:50 pm, revealed:
-In the past, MA had asked LCM to apply a topical cream to Resident #1's rash and the LCM refused because the LCM knew from the medication training that only MA can administer medications.
-Since the refusal, MAs have not asked the LCMs to apply creams.

Interviews with 2 confidential staff revealed:
-The PCM's had been asked, by the medication aide, to apply the prescription cream for Resident #1 and was given the prescription cream from the medication cart going back more than a year.
-The practice of the medication aide giving the prescription cream to the PCMs stopped after the medication error incident in October 2014.

Interview with the interium Administrator/Reminiscence Coorinator/Executive Director (ADM) on 12/18/14 at 3:45 pm, revealed:
-On 10/8/14 at 7:30 am, The ADM received a phone call from a LCM about an incident that happened at the community.
-The LCM reported to the ADM that the MA had given a PCM, who had been working at the facility a month, a cream by mouth that was supposed to be applied to Resident #1's perineal area.
-The ADM advised LCM to contact the Poison Control (PC) and follow their directions.
-The ADM contacted the Executive Director (ED) and told him of the incident.

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D 358	Continued From page 7 -The ADM questioned the LCM & MA asking " how did we end up giving the cream to a resident by mouth?" and they reported that "the PCM was given a 30 cc cup of cream to put on the resident". -The ADM did not know why the MA gave the medication to the PCM to administer to Resident #1. -The ADM asked PCM why the cream was given by mouth and PCM replied that the MA handed him a cream in a medicine cup with a spoon and said "this is for Resident #1". -It is not part of a personal care manager's (PCM) job description to give medications. -The only thing that PCMs applied was a barrier cream for incontinent residents. -PCMs had licensed health professional support (LHPS) validation checks and care training. -Care training did not include giving out medications. -MAs know not to take short cuts by giving medications to the PCMs to administer medications. -An incident report was done; the ADM took statements from the LCM, MA and PCM about the incident. Interview with Resident #1's primary care physician (PCP), on 12/17/14 at 9:05 am, revealed: -The PCP was aware of the resident's medication error incident, being fed a cream by mouth. -The PCP was also aware that Poison Control was contacted and all instructions were followed. -The resident was not harmed by the ingestion of cream and there was no negative outcome from the incident. _____ The Interium Administrator/Reminiscence	D 358		

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D 358	Continued From page 8 Coordinator/Executive Director (ADM) provided a "Plan of Protection" for all residents as follows: -Qualified medication aides preparing medications should not give medications or treatments to unqualified staff personnel to administer. -Effective 12/19/14 staff meetings will be held on all three shifts by the (ADM) to inform staff that care managers were not allowed to administer any doctor ordered prescription medications, lotions, creams, or shampoos. -Prescription medications were only to be administered by medication aides effective immediately. -All staff providing care would be given a copy of this guideline and asked to read and sign the document confirming that they understand. This document would be placed in each team member's file. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 22, 2015.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the Health Care Personnel Registry regarding treatment cream administeration by unqualified staff.	D 438		

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D 438	Continued From page 9 The findings are: Review of Resident #1's current FL-2 included the following diagnoses: hypertension (HTN), Dementia, Osteoporosis, chronic rectal prolapse with incontinence, peri-anal proctectomy with colon and incontinent of bladder and bowel. Review of Resident #1's treatment cream order revealed for Ketoconazole 2% cream/ Triamcinolone 0.1% cream, topical twice daily. (Ketoconazole cream is used to treat certain fungal infection of the skin; Triamcinolone cream is used to treat a variety of skin conditions such as eczema, dermatitis, allergies, rash) Review of the facility's incident report, dated 10/8/14, revealed: -At 6:45 am, 1st shift personal care manager (PCM) mistakenly fed Resident #1's anti-fungal, topical cream to the resident by mouth. -Poison Control was contacted; the staff was told by the agent that the resident was going to be fine. -The resident was monitored and had no apparent injury. Review of Resident #1's record revealed: -On 10/8/14, the resident was spoon fed a teaspoon of Ketoconazole 2% cream/ Triamcinolone 0.1% cream by a personal care manager (PCM). -The medication administration records (MARs) revealed that Ketoconazole 2% cream/ Triamcinolone 0.1% cream, was scheduled to be administered at 8 am and 8 pm. Interview with the 1st shift PCM, on 12/16/14 at 2:05 pm & 12/17/14 at 9:40 am, revealed:	D 438		

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D 438	Continued From page 10 -On 10/8/14, the PCM was assigned to provide routine care to Resident #1 and this was the first time a medication aide (MA) gave him a white cream in a medication cup with a teaspoon to give it to Resident #1. -When the MA gave the PCM the cream, the MA just told the PCM "this is for [Resident #1]". -The PCM was not given any instruction from the MA when the cream was given. -The PCM assumed the cream was for the mouth since the cream was thin, poured in a medication cup, and accompanied by a spoon. -The PCM gave Resident #1 a teaspoon full of the cream. -The PCM didn't know that the cream was for the resident's perineum area and the staff didn't realize an error was made until the1st shift LCM #1 told him. -The PCM reported to the LCM #1 that Resident #1's buttocks area looked redder and appeared worse. -During the PCM's job shadowing period, the PCM didn't observe Resident #1's care so was not aware that the resident was to receive a prescription cream for rash on the resident's perineum area. Review of personnel records of the1st shift PCM and 1st shift MA, on 12/18/14, revealed: -The PCM was hired on 9/3/14 as a care manager and is a nurse aide. -There was no documentation the PCM had completed a medication administration clinical skills validation checklist. -The PCM did not have the qualifications to administer medications. Review of the facility's job description for "Care Manager" did not reveal administration of medications, including topical creams, as one of	D 438		

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D 438	Continued From page 11 the duties. Interview with a 1st shift Lead Care Manager (LCM) #1 on 12/18/14 at 1:35 pm regarding facility policy on medication administration revealed: -Only the medication aide (MA) was responsible for applying prescription creams. -It did happen that the PCMs would apply the prescription creams. -The PCM had told the LCM that the PCM was given Rresident #1's cream by the MA and had given the cream orally. -The PCMs should not give out medications. -"In the PCM job description it says PCMs do not give out medications." Interview with the 2nd shift lead care manager (LCM), on 12/18/14 at 3:50 pm, revealed the LCM knew from the medication training that only MA can administer medications. Interview with the interium Administrator/Reminiscence Coorinator/Executive Director (ADM) on 12/18/14 at 3:45 pm, revealed: -The ADM did not know why the MA gave the medication to the PCM to administer to Resident #1. -The ADM asked PCM why the cream was given by mouth and PCM replied that the MA handed him a cream in a medicine cup with a spoon and said "this is for Resident #1". -The ADM questioned the LCM & MA asking " how did we end up giving the cream to a resident by mouth?" and they reported that "the PCM was given a 30 cc cup of cream to put on the resident". -It is not part of a personal care manager's (PCM) job description to give medications. -The only thing that PCMs applied was a barrier	D 438		

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D 438	Continued From page 12 cream for incontinent residents. -Care training did not include giving out medications. -The MAs know not to take short cuts by giving medications to the PCMs to administer medications.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with revelent federal and State laws and rules and regulations as related to medication administration. The findings are: Based on record review and interviews, the facility failed to assure that staff met the required medication administration qualifications when administering a prescription cream to 1 of 7 sampled residents who had a perineal rash. (Resident #1). [Refer to Tag D 912, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]	D912		